

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6653

FILED FEB 24 1944

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 142

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
2826 Angelique  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 52 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 2826 Angelique  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country. \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES LESTER WILLIAMS

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6  
year 1944 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from Feb 3 1944 to Feb 3 1944  
that I last saw him alive on Feb 3 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Gertrude Williams

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased. Sept. 4 1868  
(Month) (Day) (Year)

Immediate cause of death Mitral Stenosis

Duration ?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day

75 5 2 hr. min.

9. Birthplace Fort Dodge Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation retired engineer

11. Industry or business C.B. & Q.

12. Name John H. Williams, Sr.

13. Birthplace Dayton Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Rhoda A. Snodgrass

15. Birthplace unknown Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. L. Williams

(b) Address 2826 Angelique

17. (a) burial (b) Date thereof 2/8/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora

18. (a) Signature of funeral director Newton Beble & Bowman

(b) Address 319 South 10th

19. (a) 2/8/44 (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

Other conditions arterio scl.  
(Include pregnancy within 3 months of death)

Major findings: 928

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury 5

23. Signature Frank W. Adiguna (M. D. or other)

Address 620 Thayer Date signed 2/7/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11  
1  
7

11  
1  
7

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

10035

(Licensed Embalmer's Statement on Reverse Side)

St Joseph Mo

Dr. F. X. Hartigan  
Kirkpatrick Bldg

2-3 355

WAR 27 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address. St Joseph Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**